The Department pays for inpatient hospital services provided by acute care general hospitals using prospective payment rates based on diagnosis related groups. This payment system is described below under the heading of Payments Under the Acute Care General Hospital Prospective Payment System.

The Department pays for inpatient hospital services provided by the following types of hospitals or hospital units based on a retrospective reasonable cost reimbursement system using Medicare principles: rehabilitation hospitals, distinct part drug and alcohol detoxification rehabilitation units of general hospitals and distinct part medical rehabilitation units of general hospitals. This payment system is described under the heading of Cost Reimbursed Hospital Payment System. Public psychiatric hospitals are also paid on a cost-reimbursed basis, as described under the heading of Cost Reimbursed Hospital Payment System.

The Department pays for inpatient hospital services provided by distinct part psychiatric units of acute care general hospitals and private psychiatric hospitals using a prospective payment system. This payment system is described under the heading of Prospective Psychiatric Payment System.

The Department pays out-of-state hospitals as described under the heading of Out-of-State Hospital Payments.

ACUTE CARE GENERAL HOSPITAL PROSPECTIVE PAYMENT SYSTEM

General Policy

The Department pays for inpatient hospital services provided in a hospital unit not excluded from the prospective payment system using predetermined rates based on the diagnosis related group (DRG) into which the patient is classified.

The DRG classification system is the same as that developed for use in the Medicare program. All compensable services provided to an inpatient are covered by the prospective payment rate, except for direct care services provided by salaried practitioners and midwives who directly bill the Department for their services.

Prospective payment rates are developed from cost reports submitted by hospitals, and from each hospital's paid claims history. Costs are determined using Medicare principles unless specified otherwise.

Malpractice insurance costs. The Department does not follow the substance or retroactivity of the malpractice insurance cost rule established by 51 F.R. 11142 (April 1, 1986). Malpractice insurance costs are included in the administrative and general cost center and allocated according to established accounting procedures.

[illegible]

PAYMENTS UNDER THE [illegible] [illegible] HOSPITAL [illegible] [illegible]

[illegible] Payment Rates

[illegible] which the patient has been discharged. The hospital specific payment rate. Payment is made based [illegible] before the date of discharge.

[illegible]

[illegible]

Prospective Capital Payment System

The Department pays an amount for depreciation and interest (capital) as an add-on to the prospective payment rate. The percentage add-on is the Statewide average ratio of capital to operating costs in a base year. Effective July 1, 1996, the add-on is 5.92 percent as derived from the Fiscal Year 1992-93 base year.

Payments for Direct Medical Education Costs

(a) The Department reimburses eligible hospitals the Medical Assistance inpatient costs for direct medical education, that are determined allowable under Medicare cost principles in effect as of June 30, 1985. For purposes of calculating Medicare upper payment limits Medicare payment principles in effect as of July 1, 1985 will be utilized. For the period January 1, 1996, through December 31, 1997 providers that were eligible for direct medical education payments as of December 31, 1995, or otherwise become eligible during this term shall be eligible for direct medical education payments.

(b) Payments

(1) For the period January 1, 1996, through December 31, 1996, eligible providers shall receive monthly payments equal to their monthly payments for the period July 1, 1995, through December 31,1995, reduced by 12.06%.

(2) For the period January 1, 1997, through December 31, 1997, eligible providers shall receive monthly payments as set forth in (b)(1) increased by 13.6%.

(c) Effective January 1, 1997, eligible providers who provide inpatient acute care services to Medical Assistance managed care recipients shall also receive monthly direct medical education pass through payments as a component of the direct medical education payments described in (b)(2). Payment for direct medical education is not included in the capitation rate.

(d) Direct medical education payments shall be adjusted as necessary in accordance with the limitations set forth in Part V.

(e) Direct medical education payments shall be considered final and prospective and are not subject to cost settlement.

METHODS USED TO ESTABLISH PROSPECTIVE RATES

Computation of Relative Values

For each DRG the Department determines a relative value which reflects the cost of hospital resources used to treat cases in that DRG relative to the Statewide average cost of all cases. To compute relative values the Department uses the most recent paid claims data for at least a two year period and each hospital's most recent cost report on file. The following three steps are used to determine relative values using this information:

Step 1 - Determining the cost of each claim

The Department determines the cost for each claim by:

(1) Multiplying the claim's general care unit days by the hospital's general care unit per diem;

(2) Multiplying the claim's special care unit days, if any, by the corresponding special care unit per diem;

(3) Multiplying the ancillary charges on the invoice by a corresponding cost-to-charge ratio of the ancillary department; if

detailed ancillary charges are not available, the hospital's overall ratio of cost to charges is used; and

(4) Adding the above amounts to establish the cost of the claim.

Step 2 - Standardizing the Cost of the Claim

The cost of each claim is standardized by:

(1) Computing a hospital specific average cost per case by dividing the total cost for all claims of a hospital by the total number of claims of the hospital.

(2) Computing a Statewide average cost per case by dividing the total cost for all claims by the total number of claims;

(3) Dividing the hospital specific cost per case by the Statewide average cost per case to establish a hospital specific standardization factor; and

(4) Multiplying the cost of each hospital's claim by its corresponding standardization factor.

Step 3 - Computation of the relative values

The relative values are established by:

(1) Determining the total standardized costs for all approved claims;

(2) Determining the total number of Medical Assistance hospital cases;

(3) Dividing the total standardized cost by the total number of cases to establish a Statewide average cost per case for all cases;

(4) Classifying all claims into DRGs;

(5) Determining the total cost and total number of cases for each DRG;

(6) Dividing the total cost for each DRG by the corresponding number of cases for the DRG to establish an average cost per case for each DRG; and

(7) Dividing the average cost per case for each DRG by the Statewide average cost per case for all cases as found under (3) above to establish a relative value for each DRG.

Calculation of Hospital-Specific Payment Rates

Each hospital's base payment rate is determined by:

(a) identifying each hospital's reported Medical Assistance allowable costs from its Fiscal Year 1986-87 Cost Report (MA 336) and from this amount subtracting the following items:

(1) the Medical Assistance portion of the hospital's allowable inpatient costs for direct medical education;

(2) the Medical Assistance portion of the hospital's allowable net inpatient costs for depreciation and interest for buildings and fixtures;

(3) the hospital's costs for services previously paid as inpatient services but which are no longer paid as inpatient claims.

(b) The hospital's adjusted net medical assistance allowable cost is determined by adjusting the inpatient acute care medical assistance cost determined in (a) to account for differences between the hospital's reported medical assistance days for the base year and the medical assistance days contained in the Department's claims data base for the base year. The adjustment is determined by dividing the hospital's medical assistance claims days by the hospital's reported medical assistance days and multiplying this ratio by the hospital's adjusted inpatient acute care medical assistance cost determined in (a).

(c) The Department determines each hospital's net cost to be used in the payment rate calculation by subtracting from the net medical assistance allowable cost determined in (b) the following costs determined using the Department's paid claims data base for the 1986-87 base fiscal year:

(1) The cost outlier portion of costs for claims that qualify as cost outliers.

(2) The day outlier portion of costs for claims that qualify as day outliers.

(3) The cost of transfer claims, except for DRGs 385 and 456.

(4) The cost of the hospital's claims which are no longer paid as inpatient claims.

(5) For hospitals without a distinct part psychiatric unit enrolled in the Medical Assistance Program, the cost of psychiatric claims exclusive of the first two days of the hospital stay.

(6) For hospitals with a distinct part psychiatric unit enrolled in the Medical Assistance Program, the full costs of all psychiatric claims.

(7) For hospitals that are not approved for drug and alcohol detoxification services, the cost of drug and alcohol claims exclusive of the first two days of the hospital stay.

(8) For hospitals with a distinct part drug and alcohol unit enrolled in the Medical Assistance Program, the full costs of all drug and alcohol claims.

(d) Each hospital's net cost determined in (c) is reduced by a 1.77 percent overreporting factor to account for differences between audited and reported costs.

(e) A hospital's average cost per case for the base year is determined by dividing the hospital's costs as established in (d) by the adjusted number of medical assistance cases for that year. The adjusted number of cases is determined by:

(1) Identifying the hospital's total number of claims in the base year using the Department's paid claims data base for the base fiscal year:

(2) Subtracting from the amount in (e)(1):

(i) The number of claims identified for psychiatric services as determined in (c)(6) for hospitals with distinct part psychiatric units enrolled in the Medical Assistance Program.

(ii) The number of claims identified for drug and alcohol treatment services determined in (c)(8) for hospitals with distinct part drug and alcohol units enrolled in the Medical Assistance Program.

(iii) The number of claims identified for services previously paid as inpatient services but which are no longer paid as inpatient claims as determined in (c)(4).

(iv) The number of claims involving patient transfers, except for transfers occurring in DRGs 385 and 456 as determined in (c)(3).

(v) The number of claims identified involving medical assistance cases which were eligible for Medicare reimbursement.

(f) The hospital's average cost per case is standardized to account for case mix by dividing the hospital's average cost per case as determined in (e) by its case mix index. The resultant value is referred to as the base year case mix adjusted cost per case. The hospital's case mix index is determined by:

(1) Identifying the total number of Medical Assistance DRG cases for the hospital for the base year from the Department's paid claims data.

(2) Summing the relative values of each of the cases identified in (f)(1) to establish an aggregate relative value amount for the hospital.

(3) Dividing the hospital's aggregate relative value amount determine in (f)(2) by the number of Medical Assistance cases determined in (f)(1) to establish an average relative value or case mix index for the hospital.

(g) Subject to limits under (h), hospital specific rates are determined by trending forward the case mix adjusted cost per case determined in subsection (f) by use of the following economic adjustment factors:

(1) increasing each hospital's case mix adjusted cost per case value determined in (f) by 4.5 percent to account for Fiscal Year 1987-88 inflation.

(2) increasing the value determined in (g)(1) by 5.6 percent to account for Fiscal Year 1988-89 inflation.

(3) increasing the amount determined in (g)(2) by 5.0 percent to account for Fiscal Year 1989-90 inflation.

(4) increasing the amount determined in (g)(3) by 5.3 percent to account for Fiscal Year 1990-91 inflation.

(5) increasing the amount determined in (g)(4) by 5.2 percent to account for Fiscal Year 1991-92 inflation.

(6) increasing the amount determined in (g)(5) by 4.6 percent to account for Fiscal Year 1992-93 inflation.

(7) increasing the amount determined in (g)(6) by 4.3 percent to account for Fiscal Year 1993-94 inflation. This inflation factor is applied effective July 1, 1993, for acute care general hospitals which were eligible for volume or rural disproportionate share rate enhancements in Fiscal Year 1992-93. The inflation factor is applied effective January 1, 1994, for other acute care general hospitals.

(8) increasing the amount determined in (g)(7), effective January 1, 1995, by 3.7 percent to account for calendar year 1995 inflation.

(9) For the period January 1 1996 to December 31, 1996, each hospital's case mix adjusted cost per case value in (g)(8) is the amount as of December 31, 1995, decreased by 5 percent to account for forecast error.

(10) For the period January 1, 1997 to December 31, 1997, each hospital's case mix adjusted cost per case value in (g)(9) is increased by 2 percent.

(h) The amounts determined under (g)(9) are limited to $6,151.28 for the period January 1, 1996 to December 31, 1996. The amounts determined under (g)(10) are limited to $6,274.31 for the period January 1, 1997 to December 31, 1997.